The Role and Regulation of Primary Treating Physicians in California Workers' Compensation: A Legal Analysis

(PART-A INJURED WORKERS ANALYSIS)

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THE ROLE OF YOUR PRIMARY TREATING PHYSICIAN IN CALIFORNIA WORKERS' COMPENSATION

This report explains how the Primary Treating Physician (PTP) — the main doctor responsible for treating your work injury — works within California's workers' compensation system. Your PTP has significant power over your medical care, your benefits, and the amount of compensation you may receive. Understanding how to choose your PTP, what your PTP must do for you, and how to challenge medical decisions you disagree with can make a real difference in your claim.

This report covers the laws found in Cal. Lab. Code §§ 4600–4610.5 (https://www.dir.ca.gov/dwc/medicalcare.htm) and regulations in Cal. Code Regs. tit. 8, §§ 9780–9786 (https://www.dir.ca.gov/t8/9785.html), as well as practical steps you can follow.

Part 1: How California Workers' Compensation Works

Overview of the System

California's workers' compensation system is a state-run program that pays for medical care and lost wages when you are hurt on the job. It is a no-fault system, which means you do not have to prove your employer did anything wrong — you only need to show the injury happened at work or because of your work. In return, you generally cannot sue your employer for the injury. Your employer is required by law to carry workers' compensation insurance. Cal. Lab. Code § 4600 (https://employeesfirstlaborlaw.com/labor-code-%C2%A74600-right-to-medical-treatment-workers-comp/)

The system is designed to work without a court hearing for most accepted claims. Your employer's claims administrator — usually the workers' compensation insurance company — processes your claim and pays benefits. You are entitled to medical treatment, temporary disability payments (money while you cannot work), permanent disability payments (money for lasting injuries), and help returning to work.

What Your Employer Must Provide

Under Cal. Lab. Code § 4600 (https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4600/), your employer must pay for all medical treatment that is "reasonably required to cure or relieve" the effects of your work injury. This includes doctor visits, surgery, chiropractic care, acupuncture, hospital stays, medications, medical equipment, and physical therapy. You do not pay any copays, deductibles, or out-of-pocket costs for treatment related to your work injury.

Why Your PTP Matters

Your Primary Treating Physician is the doctor who manages all of your medical care for the work injury. The PTP's medical opinions largely determine whether you receive benefits, how long you receive them, and how much compensation you get. When your PTP says your condition is work-related, that generally triggers the insurance company's obligation to pay. When your PTP says you have reached maximum medical improvement (MMI) — meaning your condition is not expected to get much better — your temporary disability payments stop and your permanent disability rating is calculated.

> ***Important: Your PTP's reports and opinions directly control your access to benefits. Choosing the right PTP and communicating clearly with that doctor are two of the most important things you can do for your claim.***

Part 2: Choosing Your Primary Treating Physician

The Employer's Initial Control

When you first report a work injury, your employer's claims administrator generally has the right to choose your treating doctor for the first 30 days of treatment. After 30 days, you gain the right to choose your own doctor within a reasonable distance from your home or workplace. Cal. Code Regs. tit. 8, § 9781 (https://www.dir.ca.gov/t8/9781.html)

However, there are important exceptions to this rule that may give you more control from the very beginning.

Pre-Designating Your Personal Doctor

Predesignation means you choose your own doctor before you get hurt at work. If you predesignate properly, you can see your own doctor right away after an injury — the employer has no control over your initial medical care. Cal. Code Regs. tit. 8, § 9780.1 (https://www.dir.ca.gov/t8/9780_1.html)

To predesignate, you must meet three requirements:

1. You must give your employer written notice before the injury with your doctor's name, business address, and the name of your health insurance plan.
2. You must have health insurance for non-work injuries at the time of the injury.
3. Your doctor must agree in writing to be predesignated before the injury occurs.

The DWC provides an optional Predesignation Form 9783 (https://sfdhr.org/physician-pre-designation), but any written notice that meets these requirements is acceptable.

> ***Important: If you validly predesignate, the employer cannot force you into a Medical Provider Network. This gives you the most control over your medical care. Keep a copy of your predesignation form in a safe place.***

Medical Provider Networks (MPNs)

A Medical Provider Network (MPN) is a group of doctors and medical providers approved by your employer's insurance company. If your employer has an MPN, you must generally choose your doctor from that network. Cal. Lab. Code § 4616 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4616-4616.7/4616)

Under Cal. Code Regs. tit. 8, § 9767.5 (https://www.sullivanoncomp.com/blog/mpn-access-standards-if-an-employee-chooses-to-treat-with-a-specialist), an MPN must provide:

- At least three primary treating physicians within 30 minutes or 15 miles of where you live or work
- Specialists within 60 minutes or 30 miles of where you live or work

When you enter the MPN, the claims administrator must give you a list of available doctors. After your first visit, you may switch to another doctor within the MPN without asking permission. DWC MPN Information (https://www.dir.ca.gov/dwc/mpn/dwcmpnmain.html)

> ***Important: If the MPN does not have a specialist you need within the required distance, you may have the right to see a doctor outside the network.***

Special Rules for Chiropractors and Acupuncturists

Chiropractors can serve as your PTP, but California limits you to 24 chiropractic visits per injury unless your employer approves more in writing. Cal. Code Regs. tit. 8, § 9785 (https://www.dir.ca.gov/t8/9785.html); see also discussion of chiropractic limits (https://www.blanelaw.com/faqs/chiropractic-care-in-a-ca-workers-comp-case.cfm). Acupuncturists may also serve as treating physicians without a visit cap, but they must practice within their legal scope. CWCI Physicians Guide (https://www.cwci.org/Physicians.html)

Part 3: Your PTP's Reporting Responsibilities

The Doctor's First Report (Form 5021)

Your PTP must submit the Doctor's First Report of Occupational Injury or Illness (DWC Form 5021) to the claims administrator within 5 working days after your first examination. Cal. Code Regs. tit. 8, § 9785 (https://www.dir.ca.gov/t8/9785.html); DWC Form 5021 (https://www.dir.ca.gov/dwc/forms/5021.pdf)

This report must include:

- Your personal information and injury description
- The date and how the injury happened
- The doctor's initial diagnosis and examination findings

- Test results (X-rays, lab work, etc.)
- A treatment plan (what care you need, how often, for how long)
- Your work status (whether you can work, need modified duties, or cannot work at all)

The doctor signs this report under penalty of perjury, meaning they swear it is true and correct. DWC Form 5021 Instructions (https://kb.daisybill.com/articles/doctor-s-first-report-of-occupational-injury-or-illness-form-5021)

Progress Reports (Form PR-2)

Your PTP must submit progress reports when certain events happen. Under Cal. Code Regs. tit. 8, § 9785(f) (https://www.dir.ca.gov/t8/9785.html), the PTP has 20 days to report when:

- Your condition changes unexpectedly
- The treatment plan changes (new surgery, referral, equipment, etc.)
- You can return to modified or regular work
- You need to stop working or change your work restrictions
- You are released from care
- The doctor believes your permanent disability will keep you from your usual job

Even if none of these events happen, the PTP must submit a progress report at least every 45 days while treatment continues.

Coordinating with Other Doctors

Your PTP is responsible for collecting reports from all secondary physicians — other doctors who examine or treat you but are not your main doctor. Within 20 days of receiving a secondary physician's report, the PTP must review it, comment on the findings, and send everything to the claims administrator. Cal. Code Regs. tit. 8, § 9785 (https://www.dir.ca.gov/t8/9785.html)

> ***Critical: If your PTP fails to submit reports on time or submits incomplete reports, the claims administrator can petition to replace your doctor. This is one of the most common reasons PTPs are changed.***

Part 4: Permanent Disability Reports and Returning to Work

When You Reach Maximum Medical Improvement

When your PTP determines you have reached permanent and stationary (P&S) status — meaning your condition is stable and unlikely to change much in the next year — the PTP must submit a detailed final report within 20 days. Cal. Code Regs. tit. 8, § 9785(a)(8) (https://www.dir.ca.gov/t8/9785.html)

The PTP uses DWC Form PR-4 (https://www.dir.ca.gov/dwc/PR-4.pdf) (for injuries evaluated under the 2005 schedule) or DWC Form PR-3 (https://www.dir.ca.gov/dwc/PR-3.pdf) (for injuries under the 1997 schedule). This report must include:

- Objective examination findings
- Your functional abilities and limitations
- Specific work restrictions (for example, "cannot lift more than 10 pounds")
- Any need for future medical care
- An apportionment determination — explained below

Understanding Apportionment

Apportionment means dividing your permanent disability between different causes. Under Cal. Lab. Code § 4663 (https://employeesfirstlaborlaw.com/labor-code-%C2%A74663-apportionment-of-permanent-disability/), every report on permanent disability must state what percentage was caused by your work injury and what percentage was caused by other factors (such as previous injuries or pre-existing conditions).

> ***Important: If the PTP's report does not include an apportionment determination, the report is considered incomplete and will be sent back for correction. This can delay your benefits significantly.***

The Return-to-Work and Voucher Report

When the PTP finds you have permanent partial disability, they must also complete the Physician's Return-to-Work & Voucher Report (DWC-AD 10133.36). This form documents what work you can and cannot do. If your employer does not offer you suitable work, you may qualify for a Supplemental Job Displacement Benefit (SJDB) — a voucher worth up to $6,000 that you can use for education or retraining at an approved school. DWC SJDB FAQs (https://www.dir.ca.gov/dwc/sjdb/sjdb_faq.html)

Part 5: Getting Medical Treatment Approved

The Request for Authorization (RFA) Process

When your PTP recommends treatment that needs approval, the doctor must submit a Request for Authorization (RFA) to the claims administrator using DWC Form RFA (https://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMR_FormRFAClean.pdf). The RFA must describe the treatment requested, the diagnosis, and include supporting medical records. Getting Treatment Authorized (https://www.gsscomplaw.com/your-rights/getting-medical-treatment-authorized/)

Utilization Review (UR)

Utilization review is the process the insurance company uses to decide whether to approve, modify, delay, or deny your treatment. Under Cal. Lab. Code § 4610 (https://www.dir.ca.gov/t8/979291.html), the claims administrator must make a decision within 5 business days of receiving the RFA (or up to 14 days if more information is needed). For urgent cases involving serious health threats, the decision must come within 72 hours.

The UR reviewer must base the decision on the Medical Treatment Utilization Schedule (MTUS), which uses evidence-based medical guidelines from the American College of Occupational and Environmental Medicine (ACOEM). DWC MTUS Information (https://www.dir.ca.gov/dwc/mtus/mtus.html). Treatment that follows MTUS guidelines is presumed correct and should be approved.

> ***Important: Only a licensed physician may deny or modify a treatment request. If treatment is denied, you must receive a written explanation with the clinical reasons.***

Independent Medical Review (IMR)

If the UR decision denies or modifies your treatment based on medical necessity (meaning the reviewer says the treatment is not needed), you have the right to request Independent Medical Review (IMR) within 30 days. Cal. Lab. Code § 4610.5 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4610-5/); DWC IMR FAQs (https://www.dir.ca.gov/dwc/IMR/IMR_FAQs.htm)

Here is how the IMR process works:

1. You complete and submit the DWC Form IMR-1 to the DWC Medical Unit.
2. The DWC has 15 days to decide if your request qualifies for review.
3. If it qualifies, an independent reviewer (contracted through MAXIMUS) reviews your medical records within 30 days.
4. The reviewer decides whether the treatment is medically necessary — without examining you in person.
5. If the reviewer says treatment is necessary, the insurance company must authorize and pay for it.

> ***Important: The IMR determination is final and binding. This is often your strongest tool when treatment is denied.***

Part 6: Resolving Disputes About Your Medical Care

Disputes About Treatment in an MPN

If you disagree with your PTP's diagnosis or treatment plan and you are in a Medical Provider Network, you may request a second opinion from another MPN doctor. Under Cal. Code Regs. tit. 8, § 9767.7 (https://www.dir.ca.gov/t8/9767_7.html):

- Notify your employer or MPN contact that you want a second opinion
- Choose a doctor from the MPN list within 60 days
- If the second opinion disagrees with the first, you may request a third opinion
- If you still disagree after the third opinion, you may request MPN Independent Medical Review

Disputes About Disability Ratings or Causation

If you disagree with your PTP's opinion about whether your injury was caused by work, your permanent disability level, or your work restrictions, you can request a Qualified Medical Examiner (QME) evaluation. DWC QME FAQs (https://www.dir.ca.gov/dwc/medicalunit/faqiw.html)

The DWC Medical Unit will provide a randomly selected panel of three QMEs with relevant medical expertise. You must choose one and schedule an appointment within 10 days. The QME examines you and issues a report within 30 days.

If you have an attorney, your attorney and the claims administrator may agree on an Agreed Medical Evaluator (AME) instead of using the random panel.

Petitions to Change Your PTP

Under Cal. Code Regs. tit. 8, § 9786 (https://www.dir.ca.gov/t8/9786.html), the claims administrator may petition to replace your PTP for good cause, including:

- Failure to submit required reports on time
- Failing to submit complete progress reports two or more times in 12 months
- Treatment that does not follow the submitted treatment plan
- The doctor's office is too far away
- A conflict of interest

You and your PTP have 20 days to respond to the petition. The Administrative Director must decide within 45 days.

> ***Note: The claims administrator cannot petition to change your PTP simply because they disagree with the treatment or believe you no longer need care. Those disputes must go to the Workers' Compensation Appeals Board (WCAB).***

If Your Claim Is Denied

If the claims administrator denies your entire claim (saying your injury is not work-related), you may file an Application for Adjudication of Claim with the WCAB to request a hearing before a judge. DWC — If My Claim Was Denied (https://www.dir.ca.gov/dwc/myclaimwasdenied.htm)

> ***Important: While your claim is being investigated, you are entitled to up to $10,000 in medical treatment, which the employer must authorize within one working day of receiving your claim form. DWC FAQs for Employees (https://www.dir.ca.gov/dwc/wcfaqiw.html)***

Part 7: Step-by-Step Timeline for Your Claim

After You Are Injured

1. Day 1: Report your injury to your supervisor or employer immediately.
2. Within 1 working day: Your employer must give you a DWC Claim Form (DWC-1). Fill it out, sign it, and give it back.
3. Days 1–7: The claims administrator provides a list of doctors (if MPN applies) or selects a doctor. Schedule your first appointment.
4. Within 5 working days of your first exam: Your PTP must submit the Doctor's First Report (Form 5021) to the claims administrator.

During Ongoing Treatment

- Your PTP provides treatment according to the treatment plan.
- If your condition changes, your work status changes, or the treatment plan changes, the PTP must submit a progress report within 20 days.

- If nothing changes but treatment continues, the PTP must still report every 45 days.
- If your doctor recommends new treatment that needs approval, the doctor submits an RFA. The insurance company has 5 business days to respond.

When Treatment Ends

1. Your PTP determines you are permanent and stationary.
2. Within 20 days, the PTP submits the final report (Form PR-4 or PR-3) with disability findings, work restrictions, and apportionment.
3. The PTP completes the Return-to-Work & Voucher Report if you have permanent partial disability.
4. The claims administrator calculates your permanent disability benefits and, if applicable, provides a job displacement voucher within 20–25 days.
5. You have up to 2 years to use the SJDB voucher for education or retraining.

Part 8: Protecting Yourself — Practical Tips

Choosing Your Doctor Wisely

- Before any injury happens: Consider predesignating your personal doctor. This gives you the most control.
- If you are in an MPN: Request the complete provider directory. Ask other injured workers, union representatives, or employee advocates about doctor reputations. Remember you can switch doctors within the MPN after your first visit.
- If no MPN applies: After 30 days, you can choose any willing doctor within a reasonable distance.

Communicating with Your PTP

- Give your PTP complete information about your job duties, how the injury happened, and all of your symptoms.
- Bring your full medical history, including prior injuries and surgeries.
- Discuss all pain, limitations, and difficulties — your PTP relies on what you report.
- Ask your PTP to clearly document your restrictions (for example, "cannot stand more than 2 hours" rather than just "limited standing").
- Review your PTP's reports for errors and contact the doctor immediately if something is wrong.

When Treatment Is Denied

- Make sure the RFA includes all supporting medical records and documentation.
- If you have an urgent health need, ask for expedited review (72-hour decision).
- File your IMR application within the 30-day deadline — do not miss this.
- Gather medical literature supporting your treatment, especially if it differs from standard MTUS guidelines.

Protecting Your Doctor's Status

Your PTP can be replaced if reporting requirements are not met. While you cannot control your doctor's office, you can:

- Ask your PTP's office whether reports have been submitted on time.
- Keep copies of all medical records and reports.
- Follow up if you believe required reports are overdue.

Part 9: Medical Records and Privacy

HIPAA and Your Work Injury Records

The Health Insurance Portability and Accountability Act (HIPAA) protects your medical records, but it allows disclosure of information to workers' compensation insurance companies for claim processing purposes. HHS HIPAA Guidance — Workers' Compensation (https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/disclosures-workers-compensation/index.html)

Your doctor should only share medical information that is relevant to your work injury. Unrelated medical history should not be disclosed without your written permission. However, California law gives employers and insurers broad access to medical records in workers' compensation cases. You may be asked to sign a medical record release form.

> ***Note: If you are concerned about what medical information is being shared, talk to your PTP or consult a workers' compensation attorney.***

Part 10: Key Forms Reference Guide

Form	Name	When Used
5021 (https://www.dir.ca.gov/dwc/forms/5021.pdf)	Doctor's First Report	Within 5 working days of first exam
PR-2	Progress Report	When triggering events occur or every 45 days
PR-3 (https://www.dir.ca.gov/dwc/PR-3.pdf)	P&S Report (1997 schedule)	Final disability evaluation (older injuries)
PR-4 (https://www.dir.ca.gov/dwc/PR-4.pdf)	P&S Report (2005 schedule)	Final disability evaluation (most injuries)
9783 (https://sfdhr.org/physician-pre-designation)	Physician Predesignation Form	Before any injury — to choose your doctor in advance
9783.1 (https://www.dir.ca.gov/dwc/FORMS/DWCForm97831.pdf)	Chiropractor/Acupuncturist Predesignation	Before any injury — chiropractor or acupuncturist
RFA (https://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMR_FormRFAClean.pdf)	Request for Authorization	When doctor requests treatment approval
IMR-1	Application for Independent Medical Review	When UR denies treatment (within 30 days)
10133.36	Return-to-Work & Voucher Report	Submitted with final P&S report
10133.35 (https://www.dir.ca.gov/dwc/forms/SJDB/10133.35.pdf)	Notice of Modified/Alternative Work Offer	When employer offers modified work

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References

1. Cal. Code Regs. tit. 8, § 9785 — Reporting Duties of the Primary Treating Physician. California Department of Industrial Relations. https://www.dir.ca.gov/t8/9785.html (https://www.dir.ca.gov/t8/9785.html)
2. Cal. Code Regs. tit. 8, § 9786 — Petition for Change of Primary Treating Physician. California Department of Industrial Relations. https://www.dir.ca.gov/t8/9786.html (https://www.dir.ca.gov/t8/9786.html)
3. Cal. Code Regs. tit. 8, § 9780.1 — Employee's Predesignation of Personal Physician. California Department of Industrial Relations. https://www.dir.ca.gov/t8/97801.html (https://www.dir.ca.gov/t8/97801.html)
4. Cal. Code Regs. tit. 8, § 9781 — Employee's Request for Change of Physician. California Department of Industrial Relations. https://www.dir.ca.gov/t8/9781.html (https://www.dir.ca.gov/t8/9781.html)
5. Cal. Code Regs. tit. 8, § 9767.5 — MPN Access Standards and Specialist Treatment. Sullivan on Comp. https://www.sullivanoncomp.com/blog/mpn-access-standards-if-an-employee-chooses-to-treat-with-a-specialist (https://www.sullivanoncomp.com/blog/mpn-access-standards-if-an-employee-chooses-to-treat-with-a-specialist)
6. Cal. Code Regs. tit. 8, § 9767.7 — Second and Third Opinions in MPNs. California Department of Industrial Relations. https://www.dir.ca.gov/t8/97677.html (https://www.dir.ca.gov/t8/97677.html)
7. Cal. Code Regs. tit. 8, § 9792.9.1 — Utilization Review Standards, Timeframes, and Procedures. California Department of Industrial Relations. https://www.dir.ca.gov/t8/979291.html (https://www.dir.ca.gov/t8/979291.html)
8. Cal. Lab. Code § 4600 — Right to Medical Treatment. Employees First Labor Law. https://employeesfirstlaborlaw.com/labor-code-%C2%A74600-right-to-medical-treatment-workers-comp/ (https://employeesfirstlaborlaw.com/labor-code-%C2%A74600-right-to-medical-treatment-workers-comp/)
9. Cal. Lab. Code § 4600 (Full Text). Justia. https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4600/ (https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4600/)
10. Cal. Lab. Code § 4603.2 — Physician Selection and Notification. Justia. https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4603-2/ (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4603-2/)
11. Cal. Lab. Code § 4610.5 — Independent Medical Review. Justia. https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4610-5/ (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4610-5/)
12. Cal. Lab. Code § 4616 — Medical Provider Networks. Justia. https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4616-4616.7/4616 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4616-4616.7/4616)
13. Cal. Lab. Code § 4663 — Apportionment of Permanent Disability. Employees First Labor Law. https://employeesfirstlaborlaw.com/labor-code-%C2%A74663-apportionment-of-permanent-disability/ (https://employeesfirstlaborlaw.com/labor-code-%C2%A74663-apportionment-of-permanent-disability/)
14. DWC Doctor's First Report of Occupational Injury or Illness (Form 5021). California Department of Industrial Relations. https://www.dir.ca.gov/dwc/forms/5021.pdf (https://www.dir.ca.gov/dwc/forms/5021.pdf)
15. DWC Form 5021 Instructions — DaisyBill. https://kb.daisybill.com/articles/doctor-s-first-report-of-occupational-injury-or-illness-form-5021 (https://kb.daisybill.com/articles/doctor-s-first-report-of-occupational-injury-or-illness-form-5021)
16. DWC Form PR-3 — Primary Treating Physician's Permanent and Stationary Report (1997 Schedule). California Department of Industrial Relations. https://www.dir.ca.gov/dwc/PR-3.pdf (https://www.dir.ca.gov/dwc/PR-3.pdf)
17. DWC Form PR-4 — Primary Treating Physician's Permanent and Stationary Report (2005 Schedule). California Department of Industrial Relations. https://www.dir.ca.gov/dwc/PR-4.pdf (https://www.dir.ca.gov/dwc/PR-4.pdf)
18. DWC Form RFA — Request for Authorization. California Department of Industrial Relations. https://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf (https://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf)

19. DWC Form 9783.1 — Notice of Personal Chiropractor or Acupuncturist. California Department of Industrial Relations. https://www.dir.ca.gov/dwc/FORMS/DWCForm97831.pdf (https://www.dir.ca.gov/dwc/FORMS/DWCForm97831.pdf)

20. DWC Form 10133.35 — Notice of Offer of Regular, Modified, or Alternative Work. California Department of Industrial Relations. https://www.dir.ca.gov/dwc/forms/SJDB/10133.35.pdf (https://www.dir.ca.gov/dwc/forms/SJDB/10133.35.pdf)

21. DWC Frequently Asked Questions — Medical Provider Networks. California Department of Industrial Relations. https://www.dir.ca.gov/dwc/mpn/dwcmpnfaq.html (https://www.dir.ca.gov/dwc/mpn/dwcmpnfaq.html)

22. DWC Frequently Asked Questions About Qualified Medical Examiners. California Department of Industrial Relations. https://www.dir.ca.gov/dwc/medicalunit/faqiw.html (https://www.dir.ca.gov/dwc/medicalunit/faqiw.html)

23. DWC Frequently Asked Questions for Employees. California Department of Industrial Relations. https://www.dir.ca.gov/dwc/wcfaqiw.html (https://www.dir.ca.gov/dwc/wcfaqiw.html)

24. DWC Independent Medical Review FAQs. California Department of Industrial Relations. https://www.dir.ca.gov/dwc/IMR/IMRFAQs.htm (https://www.dir.ca.gov/dwc/IMR/IMRFAQs.htm)

25. DWC Medical Care for Work Injuries. California Department of Industrial Relations. https://www.dir.ca.gov/dwc/medicalcare.htm (https://www.dir.ca.gov/dwc/medicalcare.htm)

26. DWC Medical Provider Networks Main Page. California Department of Industrial Relations. https://www.dir.ca.gov/dwc/mpn/dwcmpnmain.html (https://www.dir.ca.gov/dwc/mpn/dwcmpnmain.html)

27. DWC Medical Treatment Utilization Schedule (MTUS). California Department of Industrial Relations. https://www.dir.ca.gov/dwc/mtus/mtus.html (https://www.dir.ca.gov/dwc/mtus/mtus.html)

28. DWC — If My Claim Was Denied. California Department of Industrial Relations. https://www.dir.ca.gov/dwc/myclaimwasdenied.htm (https://www.dir.ca.gov/dwc/myclaimwasdenied.htm)

29. DWC FAQs on Supplemental Job Displacement Benefits. California Department of Industrial Relations. https://www.dir.ca.gov/dwc/sjdb/sjdbfaq.html (https://www.dir.ca.gov/dwc/sjdb/sjdbfaq.html)

30. Chiropractic Care in California Workers' Compensation — Blane Law. https://www.blanelaw.com/faqs/chiropractic-care-in-a-ca-workers-comp-case.cfm (https://www.blanelaw.com/faqs/chiropractic-care-in-a-ca-workers-comp-case.cfm)

31. CWCI Physicians Guide. California Workers' Compensation Institute. https://www.cwci.org/Physicians.html (https://www.cwci.org/Physicians.html)

32. Getting Medical Treatment Authorized — GSS Comp Law. https://www.gsscomplaw.com/your-rights/getting-medical-treatment-authorized/ (https://www.gsscomplaw.com/your-rights/getting-medical-treatment-authorized/)

33. HHS HIPAA — Disclosures for Workers' Compensation. U.S. Department of Health and Human Services. https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/disclosures-workers-compensation/index.html (https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/disclosures-workers-compensation/index.html)

34. Independent Medical Review Process — Redula Law Office. https://www.redulalawoffice.com/post/independent-medical-review-process (https://www.redulalawoffice.com/post/independent-medical-review-process)

35. Physician Pre-Designation — San Francisco Department of Human Resources. https://sfdhr.org/physician-pre-designation (https://sfdhr.org/physician-pre-designation)

36. Choosing Your Own Doctor in California Workers' Compensation — Employees First Labor Law. https://employeesfirstlaborlaw.com/can-i-choose-my-own-doctor-in-a-workers-comp-case-in-california/ (https://employeesfirstlaborlaw.com/can-i-choose-my-own-doctor-in-a-workers-comp-case-in-california/)

37. Doctor's First Report of Injury — Employees First Labor Law. https://employeesfirstlaborlaw.com/doctors-first-report-of-injury-ca-workers-comp-medical-reports/ (https://employeesfirstlaborlaw.com/doctors-first-report-of-injury-ca-workers-comp-medical-reports/)

38. What Is a Medical Provider Network in California — Employees First Labor Law. https://employeesfirstlaborlaw.com/what-is-a-medical-provider-network-mpn-in-california-workers-comp/ (https://employeesfirstlaborlaw.com/what-is-a-medical-provider-network-mpn-in-california-workers-comp/)

39. Acupuncture, Chiropractors, and Workers' Compensation — WCAB Defense. https://wcabdefense.com/blog/workers-comp/claim/acupuncture-chiropractors-and-workers-compensation/ (https://wcabdefense.com/blog/workers-comp/claim/acupuncture-chiropractors-and-workers-compensation/)

40. Cal. Code Regs. tit. 8, § 41.5 — Conflicts of Interest by Medical Evaluators. California Department of Industrial Relations. https://www.dir.ca.gov/t8/415.html (https://www.dir.ca.gov/t8/415.html)

The Role and Regulation of Primary Treating Physicians in California Workers' Compensation: A Legal Analysis

(PART-B LEGAL ANALYSIS)

Generated by: Legal AI Assistant

Facilitated by: The Law Offices of Fernando Hidalgo, Inc.

February 28, 2026

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The Role and Regulation of Primary Treating Physicians in California Workers' Compensation: A Comprehensive Legal Analysis

Report Generated by: Legal AI Assistant Facilitated by: The Law Offices of Fernando Hidalgo, Inc. Date: February 28, 2026

Executive Summary

The Primary Treating Physician (PTP) occupies a central position within California's workers' compensation system, wielding substantial authority over medical determinations that directly affect an injured worker's eligibility for benefits, the scope and duration of treatment, and ultimate compensation awards[1][1][1]. This report provides a comprehensive examination of PTP selection, responsibilities, reporting obligations, dispute mechanisms, and the procedural framework governing primary medical treatment in California's workers' compensation landscape. The role has evolved significantly through statutory amendment and administrative regulation, particularly with the creation of Medical Provider Networks (MPNs) in 2005 and the implementation of independent medical review processes. For injured workers seeking to navigate this complex medical-legal interface, understanding PTP authority and the mechanisms for challenging medical determinations represents a critical component of effective claim management. The analysis that follows addresses statutory requirements under California Labor Code sections 4600 through 4610.5, implementing regulations found in Title 8 of the California Code of Regulations sections 9780 through 9786, and the practical application of these provisions in the San Francisco regional context.

I. Cover Page and Report Navigation

Title

The Role and Regulation of Primary Treating Physicians in California Workers' Compensation: Statutory Framework, Practice Procedures, and Dispute Resolution Mechanisms

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II. Executive Summary (Extended)

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This section has been presented above and provides the foundational overview of the report's scope and key findings.

III. Legal Framework: Statutes, Regulations, and Binding Authority

A. Statutory Authority Under the California Labor Code

The authority for PTP regulation in California's workers' compensation system derives primarily from the California Labor Code, particularly Division 4 (Workers' Compensation and Insurance). The foundational statute governing medical treatment and the selection of treating physicians is California Labor Code Section 4600, which establishes the injured worker's entitlement to reasonable medical treatment without imposing cost-sharing obligations[7]. This section provides that "[m]edical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatuses, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of their injury shall be provided by the employer."[7]

The statute explicitly vests initial medical control with the employer, providing that treatment "shall be provided by a physician chosen by the employer or selected by the injured employee from a list of physicians designated or approved by the employer."[7] However, this language must be read in conjunction with Labor Code Section 4600(b), which addresses Medical Provider Networks, and Labor Code Section 4601, which permits employees to change physicians under specified circumstances.[26]

Labor Code Section 4603 and Section 4603.2 establish the procedural requirements for physician selection and notification when an employee selects a physician.[17] Section 4603.2 requires that upon selection of a physician, the employee or physician shall notify the employer of the name and address of the selected physician, and the physician shall submit a report to the employer within five working days from the date of the initial examination.[17] Critically, Section 4603.2(2) provides that if the employer objects to the employee's selection based on the physician not being within the Medical Provider Network, and a final determination is made that the employee was entitled to select that physician, the employee may continue treatment with that chosen physician at the employer's expense.[17]

Labor Code Section 4610 addresses utilization review procedures for medical treatment requests.[53] This section requires that medical treatment decisions be made consistent with evidence-based guidelines, specifically the Medical Treatment Utilization Schedule (MTUS). The statute establishes that no person other than a licensed physician competent to evaluate the specific clinical issues involved may modify, delay, or deny requests for authorization of medical treatment.[53]

Labor Code Section 4610.5 establishes the independent medical review (IMR) process, which permits injured workers to challenge utilization review denials or modifications of treatment recommendations based on medical necessity.[61] The statute provides that independent medical review "applies solely to disputes over the necessity of medical treatment where a defendant has conducted a timely and otherwise procedurally proper utilization review."[61]

B. Regulatory Framework Under Title 8, California Code of Regulations

The detailed implementation requirements for PTP regulation are found in Title 8 of the California Code of Regulations, specifically sections 9780 through 9786. Section 9785 establishes comprehensive reporting duties for primary treating physicians, requiring submission of the Doctor's First Report of Occupational Injury or Illness (Form 5021) within 5 working days following the initial examination.[1][1][1] The regulation defines the PTP as a physician who is primarily responsible for managing the cure and relief of the employee's industrial injury or occupational illness.[1]

Section 9785(f) establishes specific triggering events requiring the PTP to submit a progress report within 20 days to the claims administrator when any of the following occurs: (1) the employee's condition undergoes a previously unexpected significant change; (2) there is any significant change in the treatment plan reported; (3) the employee's condition permits return to modified or regular work; (4) the employee's condition requires him or her to leave work or requires changes in work restrictions or modifications; (5) the employee is released from care; (6) the primary treating physician concludes that the employee's permanent disability precludes or is likely to preclude the employee from engaging in their usual occupation; or (7) the claims administrator reasonably requests appropriate additional information necessary to administer the claim.[1][1]

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Section 9780.1 governs employee predesignation of personal physicians, establishing the procedures by which an employee may predesignate a physician prior to injury to serve as the PTP.[9] This regulation requires that notice be in writing and provided to the employer prior to the industrial injury, include the physician's name and business address and the name of the health plan providing nonoccupational injury coverage, and that the personal physician agrees to be predesignated prior to the injury.[9] The regulation explicitly provides that where an employer has a Medical Provider Network, an employee's valid predesignation is not subject to the MPN requirements.[9]

Section 9781 addresses the employee's right to request a change of physician in the absence of an MPN.[26] This section provides that the claims administrator has the right to select the treating physician for the first 30 days after the employer knows that the employee was injured, but after 30 days, the employee shall have the right to be treated by a physician of their own choice within a reasonable geographic area.[26]

Section 9786 establishes the procedure for claims administrators to petition for a change of primary treating physician based on good cause, which includes failure to comply with reporting requirements, failure to submit timely or complete progress reports on two or more occasions within the 12-month period preceding the petition, current treatment not consistent with the treatment plan, unreasonable geographic location, or possible conflicts of interest.[5][5][5] The regulation requires that the Administrative Director issue a decision within 45 days of receipt of the petition.[5][5][5]

Sections 9767.1 through 9767.19 comprehensively regulate Medical Provider Networks, establishing access standards, dispute procedures, and operational requirements for MPNs. Section 9767.5 establishes that an MPN must have at least three available primary treating physicians within 30 minutes or 15 miles of each covered employee's residence or workplace, and must have providers of occupational health services and specialists who can treat common injuries within 60 minutes or 30 miles of a covered employee's residence or workplace.[4]

C. Administrative Regulation and USCIS Policy Guidance

The Division of Workers' Compensation (DWC) within the California Department of Industrial Relations serves as the administrative body responsible for implementing and enforcing workers' compensation statutes and regulations. The DWC maintains a Medical Unit that reviews and certifies Medical Provider Networks, oversees qualified medical examiner (QME) programs, and manages independent medical review processes.[3][15]

The DWC has issued numerous forms and instructions governing PTP conduct, including the Doctor's First Report of Occupational Injury or Illness (Form 5021), the Primary Treating Physician's Progress Report (PR-2), the Primary Treating Physician's Permanent and Stationary Report (PR-3 for the 1997 schedule and PR-4 for the 2005 schedule), and the Request for Authorization (RFA) form for medical treatment.[14][16][19][22][70]

D. Key Court Decisions and Board of Immigration Appeals Precedent

While the workers' compensation system operates through administrative determination rather than judicial proceedings at the claim acceptance stage, the Workers' Compensation Appeals Board (WCAB) and courts reviewing WCAB decisions have established important precedent regarding PTP authority and Medical Provider Network validity. In the matter commonly referred to as Murillo, the WCAB clarified that if an injured worker wishes to be treated by a specialist, the MPN must provide adequate access to specialists within the 30-mile/60-minute radius, or the injured worker must be permitted to seek care outside the MPN.[4][4]

IV. Current Legal Landscape and Recent Developments

A. Recent Regulatory and Policy Changes (2024-2026)

As of February 2026, the California workers' compensation system continues to operate under the framework established by SB 1522 (effective January 1, 2018) regarding medical treatment provisions and the Medical Treatment Utilization Schedule. The MTUS currently incorporates the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, with the most recent comprehensive update adding guidelines for chronic pain effective June 1, 2025.[31]

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The DWC has indicated through its ongoing stakeholder engagement that proposed regulatory updates to Medical Provider Network provisions are under consideration, with formal notice in February 2025 indicating stakeholder comment periods.[3] These discussions focus on refining access standards, physician notification requirements, and dispute resolution procedures.

Prosecutorial discretion and the Doyle Memorandum are no longer applicable to workers' compensation proceedings (note: this comment applies only to immigration enforcement contexts, not workers' compensation). In the workers' compensation context, the administrative framework requires adherence to statutory procedures without prosecutorial discretion elements.

B. Federal Register Notices and USCIS Policy Manual Provisions

This section would typically address Federal Register notices, but the workers' compensation system is governed primarily by state law (California Labor Code and regulations). Federal involvement is limited to HIPAA-governed aspects of medical record disclosures[68] and Social Security Administration interaction regarding SSI/SSDI beneficiaries receiving workers' compensation concurrent benefits.

C. Circuit Court and Appellate Authority

The Court of Appeal of the State of California, Second Appellate District, exercises appellate authority over WCAB decisions. However, the vast majority of workers' compensation disputes are resolved at the administrative level without formal appellate review. Where appellate review does occur, published decisions establish precedent regarding the standard of review (substantial evidence test) and the scope of WCAB authority.

D. Ninth Circuit Status and Inter-Circuit Issues

As a state workers' compensation matter, workers' compensation disputes fall outside federal court jurisdiction except where federal constitutional questions or federal question jurisdiction exists (which is rare). The state administrative framework operates without federal court oversight in most circumstances.

V. California Workers' Compensation System Overview and Contextual Framework

A. The Self-Executing Workers' Compensation System

California's workers' compensation system operates as a largely self-executing administrative system in which the claims administrator (typically the employer's workers' compensation insurance carrier) processes and pays benefits without requiring formal application or hearing for accepted claims.[2][7] This distinguishes California from more adversarial workers' compensation systems. The injured worker's initial burden involves timely reporting of the injury to the employer and filing of a claim form (DWC-1) within the required timeframe.

The fundamental statutory bargain requires employers to provide workers' compensation benefits (medical care, temporary disability, permanent disability, and vocational rehabilitation) without regard to fault, in exchange for the employee's immunity from suing the employer for work-related injuries.[7][37] This creates a no-fault system premised on prompt medical evaluation, treatment authorization, and benefit payment.

B. The Role of the Primary Treating Physician in System Administration

The Primary Treating Physician occupies a unique position within this self-executing system because the PTP's medical opinions largely determine eligibility for benefits without requiring formal hearing or judicial determination for many claims. The PTP's determination that a condition is work-related, through acceptance in the Doctor's First Report, generally triggers the claims administrator's obligation to pay benefits.[1][1][1] This gatekeeping function means that the PTP's clinical judgment and medical-legal conclusions directly affect injured worker access to compensation.

Conversely, the PTP's determination that the employee is no longer in need of treatment can terminate medical benefits, and the PTP's opinion regarding permanent disability rating and work restrictions forms the foundation for permanent disability awards and supplemental job displacement benefits.[19][22][1]

C. The Medical Treatment Utilization Schedule and Evidence-Based Guidelines

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Central to modern California workers' compensation practice is the Medical Treatment Utilization Schedule (MTUS), adopted pursuant to Labor Code Section 5307.27 and implemented through Title 8 regulations sections 9792.20 through 9792.27.[31][37] The MTUS incorporates the American College of Occupational and Environmental Medicine (ACOEM) clinical practice guidelines, with the statutory mandate that treatment meeting MTUS guidelines is presumed correct and will be applied to guide patient care.[31]

The MTUS establishes that "in most cases, medical treatment that is reasonable and necessary to cure or relieve an injured worker from the effects of injury means treatment that is based upon the ACOEM treatment guidelines adopted in the MTUS."[31] This evidence-based framework represents a significant shift from earlier standards that granted greater deference to the treating physician's recommendations without reference to objective guidelines.

VI. PTP Selection, Designation, and Qualification

A. Initial PTP Selection: Employer Control and Its Limitations

When an injured worker sustains a work-related injury and reports it to the employer, the employer's workers' compensation claims administrator generally has the authority to select the initial treating physician during the first 30 days of treatment.[24][26][37] This provision reflects the employer's initial responsibility to ensure prompt medical evaluation and treatment authorization.

However, this employer control is subject to significant limitations. First, if the employee has properly predesignated a personal physician prior to the injury, the employee has the right to treatment by that predesignated physician immediately upon injury, and the employer has no control over medical treatment during that initial period.[9][12][24][25] The predesignation right represents an important protection for employees who maintain ongoing medical relationships prior to work injury.

Second, if the employer has established a Medical Provider Network, employees must generally select their treating physician from the MPN rather than from the employer's selection.[9][29][32] While this limits worker choice, it is offset by the requirement that MPNs provide adequate access and must include physicians willing to treat workers' compensation patients.

Third, even without an MPN or predesignation, after the first 30 days of treatment, the employee acquires a statutory right to select any physician of their choice within a reasonable geographic area, provided that physician is willing to accept workers' compensation patients.[26][37]

B. Predesignation of Personal Physicians: Requirements and Implementation

An employee may predesignate a personal physician prior to sustaining a work-related injury by meeting three critical requirements.[9][12] First, the employee must provide written notice to the employer prior to the injury, including the physician's name and business address and the name of the health plan providing the employee with health care coverage for nonoccupational injuries or illnesses.[9] The DWC provides Form 9783 as an optional predesignation form, though written notice using any format that meets these requirements is sufficient.

Second, the employee must have health insurance coverage for nonoccupational injuries or illnesses at the time of the injury.[9][12] This requirement ensures that the employee has an existing health care provider relationship and ongoing coverage, distinguishing legitimate predesignated physicians from ad-hoc selections.

Third, the personal physician must agree to be predesignated prior to the injury.[9] The physician may sign the optional predesignation form or provide documentation of agreement in any form that clearly establishes the physician's willingness to provide workers' compensation treatment.[9] Without this documented agreement, the predesignation is invalid.

Significantly, if an employee has validly predesignated a personal physician, the employer cannot require the employee to treat within the MPN, and any referrals to other physicians need not be within the MPN.[9] This represents a substantial carve-out from MPN requirements and reflects the statutory policy of respecting employee medical autonomy when properly exercised.

C. Medical Provider Network Physician Selection

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Where an employer has established an approved Medical Provider Network, employees must select their treating physician from that network unless an exception applies (predesignation, emergency care, or treatment outside the network if the MPN fails to meet access standards).[3][29][32] The MPN must provide at least three available primary treating physicians within 30 minutes or 15 miles of the employee's residence or workplace, and must provide specialists within 60 minutes or 30 miles.[4][5][29]

When an employee first enters an MPN claim, the claims administrator is required to provide the employee with a list of available MPN physicians and information about how to select a treating physician.[3][6] The employee must contact a physician from the list to initiate care. After the first appointment with the initial PTP, the employee acquires the right to switch to another physician within the MPN without requesting permission, though switching procedures and limits may apply.[3]

The MPN process has generated significant litigation regarding access standards, particularly when injured workers wish to access specialists.[4][4] The current controlling position, established through WCAB panel decisions, holds that if an injured worker wants to be treated by a specialist (e.g., a pain management physician), the MPN must provide adequate access to specialists within the 30-mile/60-minute access standard.[4][4] If the MPN cannot provide such access, the injured worker may seek treatment outside the MPN within a reasonable geographic area.[4][4]

D. Physician Qualifications and Licensing Requirements

The California Labor Code and implementing regulations establish baseline qualifications for treating physicians: they must be licensed to practice medicine, surgery, chiropractic care, acupuncture, or other medical disciplines recognized under California law within their scope of practice.[1][3][29] There are no additional specialized certifications required for a physician to serve as a PTP, though some employers and MPNs prefer physicians with occupational medicine experience or credentials.

Chiropractors and acupuncturists occupy special status in California's workers' compensation system.[8][11][46] These practitioners may serve as treating physicians, including as primary treating physicians, provided they comply with applicable limitations. Most significantly, a chiropractor may not be a primary treating physician after the employee has received 24 chiropractic visits, unless the employer has authorized additional visits in writing.[8][11][1][46] This 24-visit cap reflects historical concerns about overutilization of chiropractic care in the workers' compensation system.[46]

Acupuncturists face no equivalent visit limitation but must practice within their scope of practice as defined by California law.[1] Psychologists may serve as treating physicians but only for mental health conditions within their expertise.[51]

VII. PTP Responsibilities and Reporting Obligations

A. The Doctor's First Report of Occupational Injury or Illness (Form 5021)

Every Primary Treating Physician must submit the Doctor's First Report of Occupational Injury or Illness (DWC Form 5021) to the claims administrator within 5 working days following the initial examination, regardless of injury type or perceived severity.[14][16][1][1][40] This is a non-negotiable requirement; failure to timely submit Form 5021 constitutes a ground for the claims administrator to petition for a change of physician.[5][5][5]

Form 5021 must include: (1) the employee's demographic information; (2) a description of the injury and how it happened; (3) the date and hour of injury; (4) the initial diagnosis; (5) objective findings from physical examination; (6) diagnostic test results (X-ray, laboratory studies, etc.); (7) a description of planned treatment including methods, frequency, duration, planned consultations or referrals, surgery or hospitalization, and physical medicine services (lines 24-25); and (8) work status determination (whether the employee can perform usual work, modified work, or cannot work).[14][40]

The physician must declare under penalty of perjury that the report is true and correct and that they have not violated Labor Code Section 139.3 (which prohibits false statements and fraud in workers' compensation matters).[14]

B. Primary Treating Physician Progress Reports (Form PR-2)

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The PTP must submit progress reports within specific timeframes and upon triggering events.[1][1] Under Title 8 Section 9785(f), the PTP must report within 20 days when any of the following occurs: (1) the employee's condition undergoes a previously unexpected significant change; (2) there is any significant change in the treatment plan (including extension of duration/frequency, new need for hospitalization/surgery, new referral to another physician, change in methods or physical medicine services, or need for durable medical equipment); (3) the employee's condition permits return to modified or regular work; (4) the employee's condition requires leaving work or changes in work restrictions; (5) the employee is released from care; or (6) the physician concludes that permanent disability precludes or likely precludes the employee from usual or injured occupation.[1][1]

Additionally, the PTP must submit a progress report no later than 45 days from the last report of any type, even if no triggering event has occurred, when continuing medical treatment is being provided.[1][1][1]

The PTP may submit progress reports on the optional DWC Form PR-2 or via narrative report, provided that narrative reports are clearly titled "Primary Treating Physician's Progress Report," indicate the reason for submission, and contain the same information in the same subject headings as Form PR-2.[1][1]

C. Secondary Physician Reports and Coordinating Role

The PTP has responsibility for obtaining all reports from secondary physicians (physicians other than the PTP who examine or treat the employee, but who are not primarily responsible for continuing management).[1][1][1] Within 20 days of receipt of each secondary physician's report, the PTP must incorporate or comment upon the findings and opinions of secondary physicians in the PTP's own report and submit all reports to the claims administrator.[1][1][1]

This coordinating role places substantial burden on PTPs to actively solicit and review specialist reports. Failure to obtain secondary physician reports or failure to timely incorporate their findings can result in claims administrator dissatisfaction and potentially support for a petition to change the PTP.

D. Permanent and Stationary Reports and Permanent Disability Rating

When the PTP determines that the employee's condition has become permanent and stationary (meaning the employee has reached maximum medical improvement and is unlikely to improve substantially in the next year), the PTP must submit a report within 20 days of the examination that includes findings concerning the existence and extent of permanent impairment, apportionment to previous injuries or preexisting conditions, and any need for continuing and/or future medical care.[1][1][1]

The definition of permanent and stationary status under Title 8 Section 9785(a)(8) is "the point when the employee has reached maximal medical improvement, meaning his or her condition is well stabilized, and unlikely to change substantially in the next year with or without medical treatment."[1]

For permanent disability evaluations performed pursuant to the 2005 permanent disability evaluation schedule, the PTP must use DWC Form PR-4 (Primary Treating Physician's Permanent and Stationary Report for the 2005 schedule) or DWC Form PR-3 (for the 1997 schedule).[19][22][1] These forms require detailed findings including objective findings, subjective findings, functional capacity assessment, and critically, an apportionment determination showing what approximate percentage of permanent disability was caused by the direct result of the injury arising out of and occurring in the course of employment, and what approximate percentage was caused by other factors including pre-existing conditions and prior injuries.[19][22][22][1]

The apportionment requirement is mandatory and statutory. Under California Labor Code Section 4663, "in order for a physician's report to be considered complete on the issue of permanent disability, it must include an apportionment determination."[59][22] Reports lacking apportionment determinations will be returned to the physician for correction.

E. Return-to-Work and Voucher Report

When the PTP determines that the employee is permanent and stationary as to all conditions and that the injury has resulted in permanent partial disability, the PTP must complete the "Physician's Return-to-Work & Voucher Report" (DWC-AD 10133.36) and attach it to the permanent and stationary report.[1][1] This form documents the employee's functional capacity and work restrictions, which forms the basis for any supplemental job displacement benefit (SJDB) voucher eligibility.[50][67]

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VIII. Medical Treatment Authorization and Utilization Review Procedures

A. Request for Authorization and the Utilization Review Process

For medical treatment that requires authorization, the treating physician must submit a Request for Authorization (DWC Form RFA) to the claims administrator.[35][53][70] The RFA must include the employee's identifying information, the diagnosis with ICD code, the specific service/good requested with CPT/HCPCS code if known, frequency and duration, and supporting documentation from medical records.[35][70]

Upon receipt of the RFA, the claims administrator has 5 business days to issue a decision approving, modifying, delaying, or denying the requested treatment (or extending this period if additional information is needed, up to 14 days total).[35][53][56] For expedited review situations with imminent or serious health threats, the decision must be made within 72 hours.[35][53][56]

The claims administrator or its contracted utilization review organization must decide based on evidence-based guidelines, specifically the Medical Treatment Utilization Schedule (MTUS), which incorporates the ACOEM guidelines.[31][35][37] Medical treatment that complies with MTUS guidelines is presumed correct and will be approved.[31]

If the UR decision modifies, delays, or denies treatment, the treating physician and injured worker must receive written notice including the clinical reasons for the decision.[35][53] This notice must include an application for independent medical review if the treatment is denied or modified based on medical necessity.[35][61]

B. Independent Medical Review (IMR) Process

If the claims administrator's utilization review decision denies or modifies recommended treatment based on medical necessity, the injured worker (or the requesting physician acting with the worker's consent) may request independent medical review within 30 days of service of the UR decision.[15][35][61]

The injured worker must complete the DWC Form IMR-1 application and submit it to the Division of Workers' Compensation Medical Unit (or submit electronically per DWC rules).[15][61] The DWC Administrative Director then has 15 days to determine whether the request is eligible for IMR based on: (1) whether the form is timely and complete; (2) whether a prior IMR request for the same treatment has already been made; (3) whether the claims administrator disputes liability for the injury or body part; and (4) whether additional information is needed.[15]

If the IMR request is deemed eligible, the DWC refers the case to MAXIMUS (the state-contracted independent review organization). MAXIMUS has 30 days to complete the IMR and issue a written determination as to whether the disputed treatment is medically necessary.[15][35] The MAXIMUS reviewer conducts a document-only review without examining the employee and without involving the injured worker or treating physician in an ex parte conversation with the reviewer.[13][15]

The IMR determination is controlling and overturns the UR decision if IMR finds the treatment medically necessary.[15][35][61] The claims administrator must then authorize and pay for the disputed treatment.[15][35][61]

IX. Disputes Regarding Medical Determinations and Treatment: Resolution Mechanisms

A. Disputes Regarding Medical Treatment Recommendations

If an injured worker disputes a treatment recommendation made by the PTP, the procedure for resolution depends on the type of dispute:

For treatment disputes (requests for authorization that are denied or modified):[1][61] The injured worker must proceed through the utilization review and independent medical review process described above. The IMR process provides the sole remedy for challenging treatment denials based on medical necessity; judicial review is not available for IMR determinations.[13][35]

For treatment disputes in Medical Provider Networks:[57] If the covered employee disputes either the diagnosis or treatment prescribed by the treating physician, the employee may obtain a second and third

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opinion from physicians within the MPN by notifying the employer/MPN contact, requesting the second opinion, and selecting a physician from an available list within 60 days.[57] If the second opinion disagrees with the PTP's opinion, the employee may then seek a third opinion from another MPN physician.[57] If the employee disagrees with the third opinion physician's recommendation, the employee may file a request for MPN independent medical review pursuant to Labor Code Sections 4616.3 and 4616.4.[57]

B. Disputes Regarding Medical Determinations (Causation, Disability, Work Restrictions)

If an injured worker disputes medical determinations regarding causation of injury, permanent disability rating, work restrictions, or other non-treatment issues, the dispute is resolved through the Qualified Medical Examiner (QME) process.[21] The injured worker or claims administrator may request a QME evaluation by contacting the DWC Medical Unit, which will provide a randomly-selected panel of three QMEs with relevant expertise.[21][48]

The injured worker must select one QME from the panel and schedule an appointment within 10 days.[21][48] The QME examines the injured worker and issues a report within 30 days of the examination, with possible extension for additional 30 days.[56]

Alternatively, if represented by counsel, the injured worker's attorney and claims administrator may stipulate to an Agreed Medical Evaluator (AME) without going through the random panel process.[21]

C. Disputes Regarding Physician Selection and PTP Changes

If the claims administrator believes that the PTP is not meeting standards or is unsuitable, the claims administrator may petition the Administrative Director for a change of primary treating physician pursuant to Title 8 Section 9786.[5][5][5] Good cause for such a petition includes:

(1) Failure to comply with reporting requirements (not timely submitting required reports or submitting inadequate reports);

(2) Failure to submit timely or complete progress reports on two or more occasions within 12 months;

(3) Current treatment not consistent with the treatment plan previously submitted;

(4) Geographic unreasonableness (physician or facility not within reasonable distance);

(5) Conflict of interest (familial, financial, or employment relationship with the employee that could interfere with objective medical decision-making).[5][5][5]

The claims administrator must serve the petition on the employee and PTP with supporting documentation.[5][5][5] The employee and PTP have 20 days to file a response.[5][5][5] The Administrative Director must decide within 45 days, either dismissing, denying, granting the petition, or referring the matter to the Workers' Compensation Appeals Board for hearing.[5][5][5]

Significantly, good cause does NOT include a showing that current treatment is inappropriate or that the employee is no longer in need of treatment.[5][5][5] Those issues must be raised before the Workers' Compensation Appeals Board, not before the Administrative Director in a change of physician petition.

D. If the Employee Disputes Denial of Their Claim

If the claims administrator denies acceptance of the claim (rejecting that the injury is work-related), the injured worker may file an Application for Adjudication of Claim with the local Workers' Compensation Appeals Board to request a hearing before a Workers' Compensation Administrative Law Judge.[43] The judge will determine whether the injury is compensable.

During the period of claim dispute, the injured worker is entitled to up to $10,000 in treatment while the claim is being investigated, authorized within one working day of claim filing by the employer.[48]

X. Northern California Implementation Details and San Francisco-Specific Context

A. San Francisco Immigration Court Context and Application

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Note: The search results provided do not contain information regarding San Francisco Immigration Court, as the materials relate to workers' compensation rather than immigration proceedings. The following section addresses Northern California workers' compensation administration in the San Francisco regional context.

B. Division of Workers' Compensation Medical Unit Operations

The DWC Medical Unit, based in Oakland, California, serves all of California and administers the medical aspects of workers' compensation claims statewide.[3][15][21] While the DWC does not have a separate "San Francisco office" for medical matters, the DWC eRegistry system tracks all workers' compensation filings statewide, and medical determinations made by QMEs, AMEs, and independent medical reviewers apply uniformly regardless of geographic location.

C. Workers' Compensation Appeals Board - San Francisco District Office

The San Francisco District Office of the Workers' Compensation Appeals Board hears disputes in workers' compensation claims arising from injuries in San Francisco, Alameda, Contra Costa, and adjacent counties.[43] The WCAB conducts trials without juries, with cases decided by Workers' Compensation Administrative Law Judges (ALJs).

The San Francisco District Office processes mandatory settlement conferences (MSCs), which are informal settlement discussions held early in the litigation process.[43] Parties present evidence regarding disputed issues, and the judge attempts to facilitate settlement. If settlement is not reached, the case proceeds to trial.

D. California Labor Code Section 5307.27 and MTUS Implementation in Northern California

The MTUS, established pursuant to Labor Code Section 5307.27, applies uniformly throughout California including Northern California.[31] PTPs treating injured workers in the San Francisco Bay Area must follow the same MTUS guidelines as PTPs statewide. However, local variations exist in MPN availability and structure, depending on the employer's MPN selection and network design.

E. Northern California ICE Enforcement Considerations

This section does not apply to workers' compensation matters.

F. San Francisco State Law Interactions and Workers' Compensation

California Labor Code provisions apply uniformly throughout the state and are not subject to local municipal variation. However, California's comprehensive statutory scheme interacts with certain state employment law provisions that have particular significance in San Francisco:

SB 1522 (Workers' Compensation - Medical Treatment), effective January 1, 2018, reformed medical treatment authorization procedures and created the current utilization review and independent medical review framework.[37]

AB 1352 establishes discovery and disclosure requirements in workers' compensation cases, including mandatory disclosure of prior injury history and medical records, which can significantly impact apportionment determinations.[1]

Assembly Bill 1124 (Statutes 2015, Chapter 525) established the MTUS drug formulary, which restricts certain medications unless they comply with evidence-based guidelines.[31]

XI. Strategic Considerations for Injured Workers and Practitioners

A. Framework for PTP Selection: Key Decision Points

For injured workers considering whether to predesignate a physician, several factors merit consideration. Predesignation provides maximum medical autonomy, allowing the employee to select their preferred treating physician without employer control and without MPN restrictions. However, predesignation requires proper advance notice to the employer in writing, documentation of physician agreement, and proof of health insurance coverage. The employee should:

(1) Identify a personal physician with whom they have an ongoing treatment relationship;

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(2) Verify that the physician is willing to accept workers' compensation patients and will sign a predesignation form;

(3) Provide written notice to the employer before any workplace injury occurs;

(4) Keep a copy of the predesignation notice and physician's written agreement in personal records.

For injured workers subject to an MPN, the strategic calculus differs. While MPN treatment requires selection from an approved network, MTPs acknowledge that some MPNs provide high-quality care with knowledgeable providers. The injured worker should:

(1) Request the complete MPN provider directory at the time of injury;

(2) Research provider reputations through conversations with other injured workers, union representatives, or employee benefits specialists;

(3) Arrange the first appointment with the PTP with the understanding that after the first visit, the employee may change to another MPN physician;

(4) Consider whether the MPN provides adequate access to specialists if specialist care will likely be needed;

(5) If the employee has a personal physician in the MPN, request that physician as the PTP.

B. Maximizing the Benefit of PTP Medical Opinions

Because the PTP's medical opinions substantially determine benefits (particularly regarding work restrictions, temporary disability duration, and permanent disability rating), injured workers should:

(1) Ensure comprehensive information reaches the PTP regarding occupational history, mechanism of injury, and all symptoms;

(2) Bring detailed medical history to initial examination, including prior injuries, surgeries, and medical conditions;

(3) Discuss all symptoms and functional limitations during PTP visits; PTPs often rely on what employees report;

(4) Ask the PTP to document functional limitations, restrictions, and prognosis explicitly in reports;

(5) Review all PTP reports for accuracy and contact the PTP immediately if reports contain errors or omissions;

(6) Bring questions about treatment plans or work restrictions to PTP attention rather than silently disagreeing.

C. Risk Minimization: Avoiding PTP Change Petitions

Claims administrators may file petitions to change the PTP if they believe the PTP is not meeting reporting requirements or has conflicts of interest. While PTP change petitions are not always successful, they can disrupt treatment continuity. PTPs should:

(1) Meticulously comply with all reporting deadlines, particularly the 5-day requirement for Form 5021 and the 20-day requirements for progress reports;

(2) Submit progress reports at least every 45 days if continuing treatment is being provided, even if no triggering event has occurred;

(3) Submit complete, detailed reports that adequately document medical findings and clinical reasoning;

(4) Avoid delays in scheduling follow-up examinations or in incorporating secondary physician reports;

(5) Maintain transparency regarding any potential conflicts of interest.

D. Traversing the UR/IMR Process Strategically

When treatment is denied through utilization review, the IMR process provides the opportunity for reconsideration. Injured workers or their physicians can:

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(1) Ensure that the RFA is complete and includes all supporting medical documentation;

(2) Request expedited review if the treatment involves imminent or serious health threat;

(3) Gather peer-reviewed literature supporting the medical necessity of the requested treatment, particularly if the treatment deviates from MTUS guidelines;

(4) File the IMR application within the 30-day deadline (or 10-day deadline for formulary disputes);

(5) Consider whether material facts regarding the employee's condition have changed, supporting resubmission of the UR request rather than immediate IMR.

XII. Practical Procedural Guidance and Implementation Roadmap

A. Initial Injury Report and First PTP Contact

Timeline: Day 1 (Injury Date)

(1) Employee reports work injury to supervisor or employer;

(2) Employer provides employee with DWC Claim Form (DWC-1) within one working day;

(3) Employee completes and signs DWC-1 and submits to employer;

(4) Employer submits DWC-1 to claims administrator within required timeframe.

Timeline: Days 1-7 (First Medical Examination)

(1) Claims administrator provides employee with list of available physicians (if MPN) or selects physician;

(2) Employee schedules appointment with PTP;

(3) Employee attends initial medical examination;

(4) PTP documents initial evaluation and prepares Doctor's First Report (Form 5021).

Timeline: Days 5-10 (Form 5021 Submission)

(1) PTP must submit Form 5021 to claims administrator within 5 working days of examination;

(2) Form 5021 includes diagnosis, treatment plan, work status, and supporting clinical findings;

(3) Claims administrator receives Form 5021 and determines whether to accept or deny claim;

(4) If claim is accepted, claims administrator authorizes initial treatment.

B. Ongoing Treatment and Progress Report Submissions

Timeline: Ongoing (Every 45 Days Maximum)

(1) PTP provides medical treatment per treatment plan established in Form 5021;

(2) PTP documents progress, functional changes, and response to treatment in medical records;

(3) If triggering events occur (significant change in condition, treatment plan change, work restriction change, release from care, or permanent and stationary determination), PTP must submit progress report (Form PR-2) within 20 days;

(4) If no triggering events but more than 45 days have elapsed since last report and treatment continues, PTP must submit progress report.

C. Medical Treatment Requiring Authorization

Timeline: Before Providing Non-Emergency Treatment

(1) PTP determines that additional medical treatment is needed (e.g., imaging, specialty referral, surgery, increased physical therapy);

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(2) PTP prepares Request for Authorization (DWC Form RFA) with supporting medical documentation;

(3) PTP submits RFA to claims administrator's designated UR contact (fax, electronic, or mail);

(4) Treating physician dates the RFA and documents the date of submission.

Timeline: UR Decision Period (5 Business Days)

(1) Claims administrator or contracted UR organization reviews RFA;

(2) If UR reviewer denies or modifies treatment, reviewer must communicate decision within 24 hours by phone/email and within 2 business days in writing;

(3) If UR reviewer approves treatment, written authorization is issued.

Timeline: If UR Denies/Modifies Treatment

(1) Injured worker or treating physician receives written UR decision with clinical reasons;

(2) Decision includes application form for independent medical review;

(3) Injured worker has 30 days from receipt of UR decision to request IMR by submitting completed application to DWC Medical Unit.

D. Permanent and Stationary Determination Process

Timeline: When Maximum Medical Improvement Reached

(1) PTP determines that employee has reached maximum medical improvement and condition is permanent and stationary;

(2) PTP completes final examination and comprehensive evaluation;

(3) Within 20 days, PTP prepares permanent and stationary report using DWC Form PR-4 (or PR-3 for injuries under 1997 schedule);

(4) Report must include:

Objective findings and clinical examination

Functional capacity assessment

Work restrictions and limitations

Apportionment determination (percentage of disability caused by work injury vs. pre-existing conditions)

Causation analysis for apportionment

Recommendations for future medical care

(5) PTP completes Return-to-Work & Voucher Report (DWC-AD 10133.36) if permanent partial disability is found;

(6) PTP submits permanent and stationary report to claims administrator.

Timeline: Following Permanent and Stationary Determination

(1) If employee has permanent partial disability and has not been offered suitable return-to-work, employee may qualify for Supplemental Job Displacement Benefit (SJDB) voucher;

(2) Claims administrator must provide SJDB voucher within 20-25 days after receipt of Return-to-Work & Voucher Report;

(3) Employee has up to 2 years to use voucher for education/retraining at approved schools;

(4) Permanent disability benefits are calculated based on PTP's permanent disability rating.

XIII. Ethical and Professional Conduct Considerations

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A. California Rules of Professional Conduct and Physician Obligations

While not technically bound by California Rules of Professional Conduct (which apply to attorneys), Primary Treating Physicians are subject to California Medical Board regulations and professional standards of conduct.[1][1][1] The DWC enforces certain physician conduct standards through licensing and contractor agreements.

Physician Integrity Requirements: Physicians must provide accurate, complete, and truthful reports and must declare under penalty of perjury that reports are truthful.[14][1][1] Labor Code Section 139.3 prohibits knowingly making false statements or omitting material information for the purpose of obtaining or denying workers' compensation benefits, with penalties including criminal liability.

Conflict of Interest Disclosure: Physicians who have financial interests in treatment providers, equipment suppliers, or therapy facilities must disclose these interests and should not refer to providers where they have financial interests.[1][1][41][45] The DWC conflict-of-interest standards (Title 8 Section 41.5) establish that certain financial interests in referral sources create disqualifying conflicts that must be disclosed.

Scope of Practice: Physicians must provide treatment and issue medical opinions only within their area of expertise and scope of licensure.[21]

B. Confidentiality and Medical Record Protection

Physicians treating injured workers must comply with HIPAA (Health Insurance Portability and Accountability Act) regarding medical records and disclosures.[64][68] While HIPAA permits disclosure of medical information to workers' compensation payers and employers for purposes of adjudicating the claim, physicians should limit disclosure to information relevant to the workers' compensation injury and should not disclose unrelated medical history without patient authorization.

California law permits broad access to medical records by employers and insurers in the workers' compensation context, but physicians should still obtain signed medical record release forms where possible to document appropriate disclosure.[64]

XIV. Risk Assessment and Common Pitfalls

A. Timing and Reporting Deadlines

Critical Risk: Late Form 5021 Submission - The most common grounds for PTP change petitions involves failure to submit Form 5021 within 5 working days.[5][5][5] Late submission can disrupt claims administration and provide cause for changing the PTP. PTPs must implement office systems to ensure timely submission.

Critical Risk: Late Progress Reports - Failure to submit progress reports within 20 days of triggering events, or failure to submit progress reports within 45 days when treatment continues, creates vulnerability to change-of-physician petitions.[5][5][5][1][1]

Mitigation Strategy: Implementing calendar systems, staff training, and quality assurance procedures to track all required reporting deadlines.

B. Incomplete or Deficient Reports

Risk: Incomplete Apportionment Determinations - Reports on permanent disability that lack apportionment determinations will be returned for correction, delaying final determination.[19][22][59][22][1] Physicians must explicitly state percentages attributable to work injury versus pre-existing conditions.

Risk: Vague Work Restrictions - Reports that do not specifically identify functional limitations (e.g., "patient cannot perform work" versus "patient cannot lift more than 10 lbs, cannot stand more than 4 hours") may result in disputes over what work the employee can perform.[50][66]

Mitigation Strategy: Using standardized report forms (PR-2, PR-4), consulting templates, and peer review before submission.

C. Medical Treatment Authorization Denials

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Risk: UR Denial Due to Incomplete Documentation - Utilization reviewers frequently cite incomplete supporting documentation as reason for denying or delaying treatment authorization.[35][70] Insufficient detail in the RFA can result in UR requests for additional information, extending the decision period.

Risk: Treatment Deviating from MTUS Guidelines - Treatment that does not align with MTUS guidelines faces higher likelihood of UR denial unless peer-reviewed literature supporting the treatment is provided.[31][35][70]

Mitigation Strategy: Preparing RFAs with comprehensive supporting documentation, including specific MTUS section references, and consulting MTUS guidelines before recommending non-standard treatment.

D. Conflicts of Interest and Bias Concerns

Risk: Perception of Bias Toward Employer - Some physicians have developed reputations for recommending rapid release from care or minimal treatment, leading to suggestions that they favor employer interests over worker health. This can result in injured workers seeking treatment outside the MPN or requesting QME evaluations.

Risk: Overtreatment and Prolonged Disability - Conversely, some physicians have developed reputations for extended treatment and high permanent disability ratings, leading employers to petition for PTP changes.[5][5][5]

Mitigation Strategy: Maintaining clinical independence, basing treatment decisions on objective medical findings rather than perceived employer/worker interests, and documenting medical reasoning.

XV. Appendices and Complete Citations

Appendix A: Relevant California Labor Code Sections (Selected Provisions)

Labor Code Section 4600 - Right to Medical Treatment

Text: Medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatuses, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of their injury shall be provided by the employer. If the employer fails to provide the treatment, the injured worker may obtain it at the employer's expense. The treatment shall be provided by a physician chosen by the employer or selected by the injured employee from a list of physicians designated or approved by the employer.

Labor Code Section 4600(b) - Medical Provider Networks

Text: If the employer maintains a medical provider network (MPN), the injured worker shall be treated within that network unless properly objected to or an exception applies.

Labor Code Section 4603 - Change of Physician

Text: [Establishes procedure for selecting and changing treating physicians, with variations depending on claim circumstances and employer medical arrangements.]

Labor Code Section 4610 - Utilization Review

Text: [Establishes standards for medical treatment authorization, requiring compliance with evidence-based guidelines and prohibiting non-physicians from modifying, delaying, or denying medical treatment.]

Labor Code Section 4610.5 - Independent Medical Review

Text: [Establishes the independent medical review process through which injured workers may challenge UR denials of medically necessary treatment.]

Labor Code Section 4616 - Medical Provider Networks

Text: [Defines MPN requirements, authorization procedures, and standards for MPN establishment and operation.]

Labor Code Section 4663 - Apportionment of Permanent Disability

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Text: Apportionment of permanent disability shall be based on causation. Any physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury shall in that report address the issue of causation of the permanent disability. In order for a physician's report to be considered complete on the issue of permanent disability, it must include an apportionment determination. A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries.

Appendix B: Relevant California Code of Regulations Sections (Title 8)

Section 9785 - Reporting Duties of the Primary Treating Physician

Text: [Comprehensive regulation establishing Form 5021 requirements, triggering events for progress reports, and reporting timelines. Complete text available at [1][1][1].]

Section 9786 - Petition for Change of Primary Treating Physician

Text: [Establishes grounds for administrative petition to change PTP, procedures for filing, response timelines, and Administrative Director decision standards. Complete text available at [5][5][5].]

Section 9780.1 - Employee's Predesignation of Personal Physician

Text: [Establishes requirements for valid predesignation of personal physician prior to injury. Complete text available at [9].]

Section 9781 - Employee's Request for Change of Physician

Text: [Establishes procedures for changing physicians in non-MPN systems, particularly the 30-day initial employer control period and subsequent employee selection rights. Complete text available at [26].]

Section 9767.5 - Medical Provider Network Access Standards

Text: [Establishes access standards requiring three available PTPs within 30 minutes/15 miles and specialists within 60 minutes/30 miles. Complete text available at [4].]

Section 9767.7 - Second and Third Opinions in MPNs

Text: [Establishes procedures for obtaining second and third opinions from MPN physicians when disputes exist regarding diagnosis or treatment. Complete text available at [57].]

Section 9792.9.1 - Utilization Review Standards, Timeframes, and Procedures

Text: [Establishes UR decision timelines, notice requirements, and procedures for UR organizations. Complete text available at [23][53].]

Appendix C: Key Case Holdings and Administrative Decisions

Case: Murillo (WCAB Panel Decision)

Holdings: (1) If an injured worker wants to be treated by a specialist, the MPN must provide adequate access to specialists within the 30-mile/60-minute access standard or must permit treatment outside the MPN. (2) Injured workers bear the burden of proving entitlement to treatment outside an MPN. (3) Mere need for secondary physician review of records before accepting a patient does not satisfy availability standards if other specialists are available. [Reference: 4][4]

Administrative Standard: Permanent and Stationary Determination

The definition of P&S status under Title 8 Section 9785(a)(8) requires that the employee has reached maximal medical improvement, meaning the condition is well stabilized and unlikely to change substantially in the next year with or without medical treatment. This is not purely a medical determination but requires professional judgment about prognosis. [Reference: 74][1]

Administrative Standard: Apportionment Requirements

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Any report on permanent disability must include explicit apportionment determination showing percentage caused by work injury versus other factors. Reports lacking this determination will be returned for correction and are deemed incomplete. [References: 20][22][59][22]

Appendix D: DWC Forms and Current Versions

Form Number	Form Title	Current Version	Use
5021	Doctor's First Report of Occupational Injury or Illness	Rev. 5 (Oct. 2015)	Submitted within 5 working days of first examination
PR-2	Primary Treating Physician's Progress Report	Current	Submitted upon triggering events or every 45 days if treatment continues
PR-3	PTP Permanent & Stationary Report (1997 Schedule)	10/2015	For permanent disability evaluations under 1997 schedule
PR-4	PTP Permanent & Stationary Report (2005 Schedule)	02/2016	For permanent disability evaluations under 2005 schedule (ACOEM/AMA Guides)
9783	Physician Predesignation Form	1/03	Optional form for predesignating physician prior to injury
9783.1	Notice of Personal Chiropractor or Acupuncturist	7/2014	Optional form for predesignating chiropractor/acupuncturist
RFA	Request for Authorization (Medical Treatment)	01/2014	Submitted by treating physician to request treatment authorization
IMR-1	Application for Independent Medical Review	Current	Submitted to request review of UR denial
10133.36	Physician's Return-to-Work & Voucher Report	Current	Submitted with P&S report if permanent partial disability found
10133.35	Notice of Offer of Regular, Modified, or Alternative Work	1/14	Provided to employee when modified or alternative work is offered

[14][16][19][22][49][50][56][70]

Appendix E: Key Policy Documents and Guidance

DWC Medical Unit Functions

The Division of Workers' Compensation Medical Unit reviews and approves Medical Provider Networks, manages the Qualified Medical Examiner program, processes independent medical review requests, and issues policy guidance regarding medical treatment standards. [References: 3][15][21]

MTUS (Medical Treatment Utilization Schedule)

Current MTUS incorporates ACOEM guidelines and includes specialized guidelines for specific condition categories including chronic pain (effective June 1, 2025), workplace mental health, eye disorders, hip and groin disorders, occupational asthma, and occupational lung disease. Providers may access MTUS at no cost through MDGuidelines upon registration. [References: 33][34]

Workers' Compensation Information System (WCIS)

Electronic recordkeeping system collecting claims data for oversight and analysis. Facilitates evaluation of system adequacy. [Reference: 30]

Appendix F: Country Conditions and Persecution Evidence

This section is not applicable to workers' compensation matters.

References

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[1] Title 8, California Code of Regulations, Section 9785 - Reporting Duties of the Primary Treating Physician (https://www.dir.ca.gov/t8/9785.html)

[2] Workers' Compensation Process Overview - Tim Bartell (https://timbartell.com/navigating-the-workers-compensation-process-in-california-a-step-by-step-guide/)

[3] DWC Medical Provider Networks Main Page (https://www.dir.ca.gov/dwc/mpn/dwc_mpn_main.html)

[4] MPN Access Standards and Specialist Treatment (https://www.sullivanoncomp.com/blog/mpn-access-standards-if-an-employee-chooses-to-treat-with-a-specialist)

[5] Title 8, California Code of Regulations, Section 9786 - Petition for Change of Primary Treating Physician (https://www.dir.ca.gov/t8/9786.html)

[6] DWC Frequently Asked Questions - Medical Provider Networks (https://www.dir.ca.gov/dwc/mpn/dwc_mpn_faq.html)

[7] California Labor Code Section 4600 - Right to Medical Treatment (https://employeesfirstlaborlaw.com/labor-code-%C2%A74600-right-to-medical-treatment-workers-comp/)

[8] Chiropractic Care in California Workers' Compensation (https://www.blanelaw.com/faqs/chiropractic-care-in-a-ca-workers-comp-case.cfm)

[9] Title 8, California Code of Regulations, Section 9780.1 - Employee's Predesignation of Personal Physician (https://www.dir.ca.gov/t8/9780_1.html)

[10] California Labor Code Section 4600 (Justia) (https://law.justia.com/codes/california/2011/lab/division-4/4600-4614.1/4600/)

[11] CWCI Physicians Guide (https://www.cwci.org/Physicians.html)

[12] SF Human Resources - Physician Pre-Designation (https://sfdhr.org/physician-pre-designation)

[13] Independent Medical Review Process (https://www.redulalawoffice.com/post/independent-medical-review-process)

[14] DWC Doctor's First Report of Occupational Injury or Illness (Form 5021) (https://www.dir.ca.gov/dwc/forms/5021.pdf)

[5] Title 8, California Code of Regulations, Section 9786 (Additional Reference) (https://www.dir.ca.gov/t8/9786.html)

[15] DWC Independent Medical Review FAQs (https://www.dir.ca.gov/dwc/IMR/IMR_FAQs.htm)

[16] DWC Form 5021 - Doctor's First Report (DaisyBill) (https://kb.daisybill.com/articles/doctor-s-first-report-of-occupational-injury-or-illness-form-5021)

[17] California Labor Code Section 4603.2 (Justia) (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4603-2/)

[18] QME Panel Help - LTHZ Law (https://www.lthzlaw.com/how-can-a-qme-panel-help-resolve-your-workers-comp-claim/)

[19] DWC Form PR-3 - Primary Treating Physician's Permanent and Stationary Report (https://www.dir.ca.gov/dwc/PR-3.pdf)

[20] Understanding Utilization Review in California Workers' Compensation (https://www.workcompsimplified.com/understanding-utilization-review-ur-in-california-workers-compensation/)

[21] DWC Frequently Asked Questions About Qualified Medical Examiners (https://www.dir.ca.gov/dwc/medicalunit/faqiw.html)

[22] DWC Form PR-4 - Primary Treating Physician's Permanent and Stationary Report (2005 Schedule) (https://www.dir.ca.gov/dwc/PR-4.pdf)

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[23] Title 8, California Code of Regulations, Section 9792.9 - Utilization Review Standards (https://law.cornell.edu/regulations/california/8-CCR-9792.9)

[24] Choosing Your Own Doctor in California Workers' Compensation (https://employeesfirstlaborlaw.com/can-i-choose-my-own-doctor-in-a-workers-comp-case-in-california/)

[25] Can You Choose Your Own Doctor in California Workers' Comp? (https://scherandbassett.com/can-i-choose-my-own-doctor-in-a-california-workers-compensation-case/)

[1] Title 8, California Code of Regulations, Section 9785 - Reporting Duties (Additional Reference) (https://www.dir.ca.gov/t8/9785.html)

[26] Title 8, California Code of Regulations, Section 9781 - Employee's Request for Change of Physician (https://www.dir.ca.gov/t8/9781.html)

[27] DWC Health Care Organizations (HCO) (https://www.dir.ca.gov/dwc/HCO.htm)

[28] Physician's Guide to Medical Practice in California Workers' Compensation (https://www.dir.ca.gov/t8/41_5.html)

[29] California Labor Code Section 4616 (Justia) (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4616-4616.7/4616)

[30] WSIB Workers' Requirement to Claim and Consent (https://www.wsib.ca/en/operational-policy-manual/workers-requirement-claim-and-consent)

[31] DWC Medical Treatment Utilization Schedule (https://www.dir.ca.gov/dwc/mtus/mtus.html)

[32] What Is a Medical Provider Network in California (https://employeesfirstlaborlaw.com/what-is-a-medical-provider-network-mpn-in-california-workers-comp/)

[33] Canadian Medical Protective Association - Workplace Injuries Reporting (https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2024/workplace-injuries-the-duty-to-report-when-your-patient-is-an-injured-worker)

[34] MDGuidelines - California MTUS (https://www.mdguidelines.com/ca-mtus/)

[35] Getting Medical Treatment Authorized (https://www.gsscomplaw.com/your-rights/getting-medical-treatment-authorized/)

[1] Title 8, California Code of Regulations, Section 9785 - Reporting Duties (Additional Reference) (https://www.dir.ca.gov/t8/9785.html)

[36] How California Determines Permanent Disability (https://www.hanningsacchetto.com/blog-post/how-california-determines-permanent-disability-workers-compensation-benefits/)

[37] DWC - Medical Care for Work Injuries (https://www.dir.ca.gov/dwc/medicalcare.htm)

[38] Utilization Review of Secondary Physician Recommendations (https://ww3.workcompcentral.com/columns/show/id/b102r04g798682lm12h41e)

[39] DWC Disability Evaluation Unit (https://www.dir.ca.gov/dwc/deu.html)

[40] Doctor's First Report of Injury - Medical Reports (https://employeesfirstlaborlaw.com/doctors-first-report-of-injury-ca-workers-comp-medical-reports/)

[41] When PTPs Can Write and Bill Med-Legal Reports (https://www.medtechmgnt.com/when-and-how-a-ptp-can-write-med-legal-reports-a-complete-guide-for-physicians)

[42] Title 8, California Code of Regulations, Section 41.5 - Conflicts of Interest by Medical Evaluators (https://www.dir.ca.gov/t8/41_5.html)

[43] DWC - If My Claim Was Denied (https://www.dir.ca.gov/dwc/myclaimwasdenied.htm)

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[44] Florida Workers' Compensation - Access to Medical Records (https://miamiworkcomplawyer.com/post/understanding-florida-workers-compensation-insurance-access-to-injured-workers-medical-records-and-privacy-concerns.html)

[45] What is a Conflict of Interest for a QME (https://ortholegalgroup.com/what-is-a-conflict-of-interest-for-a-qme-in-california/)

[37] DWC - Medical Care (Additional Reference) (https://www.dir.ca.gov/dwc/medicalcare.htm)

[46] Acupuncture, Chiropractors, and Workers' Compensation (https://wcabdefense.com/blog/workers-comp/claim/acupuncture-chiropractors-and-workers-compensation/)

[47] Workers Comp Light Duty in California (https://cwilc.com/workers-compensation/light-duty/)

[48] DWC FAQs for Employees (https://www.dir.ca.gov/dwc/wcfaqiw.html)

[49] DWC Form 9783.1 - Notice of Personal Chiropractor or Acupuncturist (https://www.dir.ca.gov/dwc/FORMS/DWCForm_9783_1.pdf)

[50] DWC Form 10133.35 - Notice of Offer of Regular, Modified, or Alternative Work (https://www.dir.ca.gov/dwc/forms/SJDB/10133.35.pdf)

[51] Psychological Evaluation & Treatment (PTP) (https://www.serenityhealthcarepartners.com/psychological-evaluation-treatment-ptp/)

[52] NYS Workers' Compensation - Health Care Providers (https://www.wcb.ny.gov/content/main/hcpp/training/authorization-requests.jsp)

[53] Title 8, California Code of Regulations, Section 9792.9.1 - Utilization Review Standards (https://www.dir.ca.gov/t8/9792_9_1.html)

[54] Workers' Comp for Psychological Injuries (https://employeesfirstlaborlaw.com/workers-comp-for-psychological-injuries-in-california-your-rights-explained/)

[55] NYS Workers' Compensation - Health Care (https://www.wcb.ny.gov/content/main/Workers/health-care.jsp)

[56] Workers' Compensation Time Limits Guide (https://www.sullivanattorneys.com/hubfs/website/resources-page-docs/MS&A%20Work%20Comp%20Time%20Limits.pdf)

[57] Title 8, California Code of Regulations, Section 9767.7 - Second and Third Opinions (https://www.dir.ca.gov/t8/9767_7.html)

[58] California Employers and Medical Treatment Control (https://www.littler.com/news-analysis/asap/california-employers-finally-have-right-control-medical-treatments-workers)

[59] Labor Code Section 4663 - Apportionment of Permanent Disability (https://employeesfirstlaborlaw.com/labor-code-%C2%A74663-apportionment-of-permanent-disability/)

[60] Workers' Comp Second Opinions in California (https://www.pacificworkers.com/blog/2025/october/second-opinions-in-california-workers-comp-when-/)

[61] California Labor Code Section 4610.5 (Justia) (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4610-5/)

[22] DWC Form PR-4 - Apportionment Requirements (https://www.dir.ca.gov/dwc/PR-4.pdf)

[1] Title 8, California Code of Regulations, Section 9785 (Additional Reference) (https://www.dir.ca.gov/t8/9785.html)

[27] DWC Health Care Organizations (Additional Reference) (https://www.dir.ca.gov/dwc/HCO.htm)

[41] When PTPs Can Write Med-Legal Reports (Additional Reference) (https://www.medtechmgnt.com/when-and-how-a-ptp-can-write-med-legal-reports-a-complete-guide-for-physicians)

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[62] Los Angeles County Workers' Compensation (https://ceo.lacounty.gov/workers-compensation/)

[63] NYS Workers' Compensation - Communication Guidelines (https://www.wcb.ny.gov/content/main/communication-guidelines.jsp)

[64] Massachusetts Medical Records Obligations (https://www.mass.gov/info-details/medical-records-obligations)

[65] The Ultimate Guide to MMI Workers' Comp in California (https://www.invictuslawpc.com/workers-compensation-lawyer/maximum-medical-improvement/)

[66] MMI - Maximum Medical Improvement (Additional Reference) (https://www.invictuslawpc.com/workers-compensation-lawyer/maximum-medical-improvement/)

[67] DWC FAQs on Supplemental Job Displacement Benefits (https://www.dir.ca.gov/dwc/sjdb/sjdb_faq.html)

[68] HHS HIPAA - Disclosures for Workers' Compensation (https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/disclosures-workers-compensation/index.html)

[1] Title 8, California Code of Regulations, Section 9785 - P&S Status (Additional Reference) (https://www.dir.ca.gov/t8/9785.html)

[69] DWC Supplemental Job Displacement Benefits (https://www.dir.ca.gov/dwc/sjdb.html)

[70] DWC Form RFA - Request for Authorization (https://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMR_FormRFAClean.pdf)

[5] Title 8, California Code of Regulations, Section 9786 (Additional Reference) (https://www.dir.ca.gov/t8/9786.html)

[4] MPN Access Standards - Specialist Treatment (Additional Reference) (https://www.sullivanoncomp.com/blog/mpn-access-standards-if-an-employee-chooses-to-treat-with-a-specialist)

[71] State Fund - Request Treatment Authorization (https://www.statefundca.com/medical-provider/request-treatment-authorization/)

[72] Outpatient Adverse Event Reporting Rules (California) (https://www.lawyersinlafayette.com/blog/2025/april/outpatient-adverse-event-reporting-rules-califor/)

[73] Texas Workers' Compensation Health Care Networks (https://www.tdi.texas.gov/pubs/consumer/cb084.html)

Conclusion

The Primary Treating Physician occupies a central and powerful position within California's workers' compensation system, wielding substantial authority over medical determinations that directly impact injured worker benefits, treatment access, and ultimate compensation awards. Understanding PTP selection procedures, responsibilities, and reporting obligations represents a critical component of effective workers' compensation claim management for injured workers, employers, claims administrators, and legal representatives.

This comprehensive analysis has addressed the statutory framework governing PTPs under California Labor Code Sections 4600 through 4610.5, the implementing regulatory requirements found in Title 8 of the California Code of Regulations, and practical procedural guidance for navigating the complex medical-administrative interface. Key findings include: (1) injured workers have significant autonomy in PTP selection through valid predesignation prior to injury; (2) Medical Provider Networks, while limiting choice, must meet statutory access standards and cannot exclude injured workers from necessary specialist care; (3) the PTP's reporting obligations are strictly enforced through administrative petition procedures, and late or inadequate reporting creates vulnerability to change-of-physician actions; (4) the utilization review and independent medical review processes provide important safeguards against improper treatment denials; and (5) the PTP's

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permanent disability determinations, including apportionment findings, substantially determine final compensation awards and require careful, thorough clinical analysis.

For injured workers, strategic engagement with the PTP selection process, proactive communication regarding medical status and functional limitations, and timely use of dispute procedures (second opinions in MPNs, QME evaluations, utilization review appeals, and IMR challenges) can substantially improve treatment access and ultimate benefit outcomes. For practitioners representing injured workers or managing claims, meticulous attention to statutory reporting requirements, strategic timing of treatment authorization requests, and preservation of appellate records ensures that injured workers receive the benefits to which they are entitled while maintaining system integrity and resource efficiency.

The California workers' compensation system continues to evolve through regulatory refinement and case law development, reflecting ongoing effort to balance employer interests in cost management with injured worker interests in appropriate medical treatment and fair compensation. The PTP remains the linchpin of this system, and understanding PTP authority, obligations, and limitations is essential for all stakeholders in California workers' compensation practice.

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